FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 N. Pulaski Road (Number) Chicago (City) 60630 (Zip Code)

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

IDPA ID Number: 36-3980966

Date of Initial License for Current Owners: 11-May-1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 28-March-2002 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1-Nov-2001

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	94	31,270	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	166	57,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,944	3,269	2,976	10,189	8
9	SNF/PED					9
10	ICF	38,736	5,152	1	43,889	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,680	8,421	2,977	54,078	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.97%

D. How many bed-hold days during this year were paid by Public Aid? 680 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11-May-1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11-May-1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 94 and days of care provided 2,812

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	298,915	44,081	13,497	356,493		356,493		356,493			1
2	Food Purchase		266,661		266,661	(19,934)	246,727	(229)	246,498			2
3	Housekeeping	204,881	31,348	24,471	260,700		260,700		260,700			3
4	Laundry	40,494	2,483	231,679	274,656		274,656		274,656			4
5	Heat and Other Utilities			212,098	212,098		212,098		212,098			5
6	Maintenance	92,277	41,865	149,365	283,507		283,507	29,366	312,873			6
7	Other (specify):*											7
8	**TOTAL General Services**	636,567	386,438	631,110	1,654,115	(19,934)	1,634,181	29,137	1,663,318			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	2,163,196	119,963	149,362	2,432,521		2,432,521		2,432,521			10
10a	Therapy			25,342	25,342		25,342		25,342			10a
11	Activities	158,952	11,745	1,500	172,197		172,197		172,197			11
12	Social Services	79,943		1,356	81,299		81,299		81,299			12
13	Nurse Aide Training			10,579	10,579		10,579		10,579			13
14	Program Transportation											14
15	Other (specify):* Dental Services			1,545	1,545		1,545		1,545			15
16	**TOTAL Health Care and Programs**	2,402,091	131,708	205,284	2,739,083		2,739,083		2,739,083			16
	C. General Administration											
17	Administrative	73,145		179,000	252,145		252,145	(141,340)	110,805			17
18	Directors Fees											18
19	Professional Services			32,538	32,538		32,538	10,610	43,148			19
20	Dues, Fees, Subscriptions & Promotions			61,717	61,717		61,717	(35,380)	26,337			20
21	Clerical & General Office Expenses	159,406	49,078	188,090	396,574		396,574	64,244	460,818			21
22	Employee Benefits & Payroll Taxes			450,422	450,422	19,934	470,356	22,492	492,848			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,511	5,511		5,511	192	5,703			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,437	53,437		53,437	266	53,703			26
27	Other (specify):*							12,017	12,017			27
28	**TOTAL General Administration**	232,551	49,078	970,715	1,252,344	19,934	1,272,278	(66,899)	1,205,379			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,271,209	567,224	1,807,109	5,645,542		5,645,542	(37,762)	5,607,780			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairmont Care Centre #0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			222,774	222,774		222,774	214,999	437,773			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			330,391	330,391		330,391	(96,590)	233,801			32
33	Real Estate Taxes			176,067	176,067		176,067		176,067			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(900,000)				34
35	Rent-Equipment & Vehicles			2,860	2,860		2,860		2,860			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,632,092	1,632,092		1,632,092	(781,591)	850,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,974	49,127	125,101		125,101		125,101			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,325	86,325		86,325		86,325			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		75,974	135,452	211,426		211,426		211,426			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,271,209	643,198	3,574,653	7,489,060		7,489,060	(819,353)	6,669,707			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	152,255	30		9
10	Interest and Other Investment Income	1,512	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(698)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,281)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,265)	20		28
29	Other-Attach Schedule **Deferred Maintenance Cost**	26,975	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 139,269		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(958,622)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (958,622)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (819,353)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost	$ 26,975	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	26,975		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(229)	0	0	0	0	0	0	0	0	0	0	(229)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	26,975	0	2,391	0	0	0	0	0	0	0	0	29,366	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	26,746	0	2,391	0	0	0	0	0	0	0	0	29,137	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(141,340)	0	0	0	0	0	0	0	0	(141,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	10,610	0	0	0	0	0	0	0	0	10,610	19
20	Fees, Subscriptions & Promotions	(41,244)	0	5,864	0	0	0	0	0	0	0	0	(35,380)	20
21	Clerical & General Office Expenses	0	15	64,229	0	0	0	0	0	0	0	0	64,244	21
22	Employee Benefits & Payroll Taxes	0	0	22,492	0	0	0	0	0	0	0	0	22,492	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	192	0	0	0	0	0	0	0	0	192	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	266	0	0	0	0	0	0	0	0	266	26
27	Other (specify):*	0	0	12,017	0	0	0	0	0	0	0	0	12,017	27
28	**TOTAL General Administration**	(41,244)	15	(25,670)	0	0	0	0	0	0	0	0	(66,899)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,498)	15	(23,279)	0	0	0	0	0	0	0	0	(37,762)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Fairmont Care Centre** **# 0040493** **Report Period Beginning:** **01/01/2001** **Ending:** **12/31/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	152,255	61,971	773	0	0	0	0	0	0	0	0	214,999	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,512	218,196	(316,298)	0	0	0	0	0	0	0	0	(96,590)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(900,000)	0	0	0	0	0	0	0	0	0	(900,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	153,767	(619,833)	(315,525)	0	0	0	0	0	0	0	0	(781,591)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	139,269	(619,818)	(338,804)	0	0	0	0	0	0	0	0	(819,353)	45

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental	$ 225,000	Fairmont Property, LLC	100.00%	$	$ (225,000)	1
2	V	32	Interest	3,261	Fairmont Property, LLC	100.00%	96,667	93,406	2
3	V	30	Depreciation		Fairmont Property, LLC	100.00%	15,493	15,493	3
4	V	21	Office Expenses		Fairmont Property, LLC	100.00%	15	15	4
5	V								5
6	V	34	Rental	675,000	Fairmont Associates	100.00%		(675,000)	6
7	V	32	Interest	96,588	Fairmont Associates	100.00%	221,378	124,790	7
8	V	30	Depreciation		Fairmont Associates	100.00%	46,478	46,478	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 999,849			$ 380,031	$ * (619,818)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salary - Cynthia & Laurence	$	Lancaster, Ltd.	100.00%	$ 18,692	$ 18,692	15
16	V	27	Payroll Taxes-Cynthia & Laurence		Lancaster, Ltd.	100.00%	640	640	16
17	V								17
18	V	17	Management Fee Income	174,800	Lancaster, Ltd.	100.00%		(174,800)	18
19	V	19	Professional Services		Lancaster, Ltd.	100.00%	10,610	10,610	19
20	V	21	Office Expenses		Lancaster, Ltd.	100.00%	2,861	2,861	20
21	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	22,492	22,492	21
22	V	24	Education & Seminars		Lancaster, Ltd.	100.00%	192	192	22
23	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	14,768	14,768	23
24	V	20	Marketing		Lancaster, Ltd.	100.00%	5,624	5,624	24
25	V	32	Interest	327,613	Lancaster, Ltd.	100.00%	11,315	(316,298)	25
26	V	30	Depreciation		Lancaster, Ltd.	100.00%	773	773	26
27	V	26	Professional Liability Ins.		Lancaster, Ltd.	100.00%	266	266	27
28	V	20	Licenses and Fees		Lancaster, Ltd.	100.00%	240	240	28
29	V	6	Maintenance		Lancaster, Ltd.	100.00%	2,391	2,391	29
30	V	21	Salary - Clerical		Lancaster, Ltd.	100.00%	61,368	61,368	30
31	V	27	Payroll Taxes - Clerical		Lancaster, Ltd.	100.00%	11,377	11,377	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 502,413			$ 163,609	$ * (338,804)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Cynthia Chow	Officer	Administrative	42.50%	See Attached	2	2.50%	Lancaster	$ 3,692	17-7	1
2	Laurence Zung	Officer	Administrative	42.50%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3	Christopher Vicere	V.P. - Finance	Administrative	10.00%	See Attached	5	10.41%	Lancaster	43,967	21-1 & 21-7	3
4	Cheryl Morris	V.P. - Operations	Administrative	5.00%	See Attached	5	10.41%	Lancaster	10,288	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,947		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 478-3699
Fax Number: (773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 120,000	$ 120,000	2	$ 3,692	1
2	27	Cynthia Chow	Hours Worked	65	7	6,835		2	210	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,315		2	430	4
5										5
6										6
7	19	Professional Services	Management Fees	1,697,900	7	103,061		174,800	10,610	7
8	21	Office Expenses	Management Fees	1,697,900	7	27,792		174,800	2,861	8
9	22	Employee Benefits	Management Fees	1,697,900	7	218,469		174,800	22,492	9
10	24	Education & Seminars	Management Fees	1,697,900	7	1,868		174,800	192	10
11	17	Administrative Consultant	Management Fees	1,697,900	7	143,451		174,800	14,768	11
12	20	Marketing	Management Fees	1,697,900	7	54,625		174,800	5,624	12
13	32	Interest	Management Fees	1,697,900	7	109,907		174,800	11,315	13
14	30	Depreciation	Management Fees	1,697,900	7	7,511		174,800	773	14
15	26	Professional Liability Ins.	Management Fees	1,697,900	7	2,588		174,800	266	15
16	20	Licenses and Fees	Management Fees	1,697,900	7	2,330		174,800	240	16
17	6	Maintenance	Management Fees	1,697,900	7	23,228		174,800	2,391	17
18	21	Salary - Clerical	Management Fees	1,697,900	7	596,087	596,087	174,800	61,368	18
19	27	Payroll Taxes - Clerical	Management Fees	1,697,900	7	110,511		174,800	11,377	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,898,578	$ 1,076,087		$ 163,609	25

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Harston Investments		X				$	$			$ 221,111	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X								Prime	11,315	6
7	A-1 Insurance Finance		X	Insurance Premiums Financed							906	7
8	Devon Bank		X								469	8
9	TOTAL Facility Related						$	$			$ 233,801	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 233,801	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	190,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	182,088	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,912)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	183,979	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	176,067	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	120,126	8
	1997	159,194	9
	1998	162,020	10
	1999	178,617	11
	2000	180,668	12

****Based on 2000 actual Taxes increased for inflation****

****Previous Year's Tax assessed - $ 1420.00****

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-009-0000	Long-Term Healthcare	$ 180,667.58	$ 180,667.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,667.58	$ 180,667.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility	218,869	1995	$ 685,000	1
2					2
3	TOTALS	218,869		$ 685,000	3

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166		1995		$ 2,240,980	$ 57,370	20	$ 112,049	$ 54,679	$ 757,448	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Canopy and Awning			1995	3,300	85	20	165	80	1,100	9
10	Intercom System			1995	1,844	47	20	92	45	586	10
11	Roof Exhausters			1996	2,136	55	20	107	52	571	11
12	Permanent Signage			1997	16,625	1,197	15	1,663	466	6,929	12
13	Fire Alarm			1997	68,600	1,759	20	3,430	1,671	14,578	13
14	Parking Lot Excavation			1997	45,000	3,240	15	4,500	1,260	19,125	14
15	Parking Lot Asphalt			1997	68,000	4,895	15	3,400	(1,495)	14,450	15
16	Concrete Curbs			1997	18,000	1,296	15	900	(396)	3,825	16
17	Phase I Expansion-Landscaping			1997	41,000	2,952	15	2,050	(902)	8,713	17
18	Site Sewer			1997	28,500	2,052	15	1,425	(627)	6,056	18
19	Phase I Expansion-Building			1997	1,218,394	31,241	20	60,920	29,679	258,910	19
20	Ceramic Tiled Hallway			1998	10,603	272	15	530	258	1,943	20
21	Electrical Enhancements			1998	6,210	159	15	311	152	1,140	21
22	Phase II-Landscape			1999	15,000	1,283	15	1,283		3,458	22
23	Site Sewer			1999	40,376	3,452	15	3,452		9,307	23
24	Fire Protection			1999	43,440	1,114	20	1,114		2,553	24
25	Excavation			1999	49,650	4,245	15	4,245		11,445	25
26	Phase II Expansion			1999	2,281,933	58,511	20	58,511		134,088	26
27	Electrical-Courtyard			2001	6,520	160	15	160		160	27
28	Building Roofing			2001	21,919	117	20	117		117	28
29	Garage Roofing			2001	7,500	40	20	40		40	29
30	Heating System			2001	17,965	96	15	96		96	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,253,495	$ 175,638		$ 260,559	$ 84,921	$ 1,256,637	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,351,944	$ 96,264	$ 163,598	$ 67,334	10	$ 810,941	71
72	Current Year Purchases	68,610	13,616	13,616		10	13,616	72
73	Fully Depreciated Assets	7,307					7,307	73
74								74
75	TOTALS	$ 1,427,861	$ 109,880	$ 177,214	$ 67,334		$ 831,864	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,366,356	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 285,518	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 437,773	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 152,255	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,088,501	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	$ 179,744	$ 4,601	$ 30,478	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 179,744	$ 4,601	$ 30,478	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,860 Description: Motorised Chair/Dialysis Unit (June-July)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 32

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		107	959		1,066
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments			9,513		9,513
8	Nurse Aide Competency Tests					
9	TOTALS		$ 107	$ 10,472	$	$ 10,579
10	SUM OF line 9, col. 1 and 2	(e)	$ 10,579			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	20

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 17,199	$		$ 17,199	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,243			4,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			27,685			27,685	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				50,377		50,377	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies	39-2					12,488		12,488	13
	Other (specify): Rental Speciality Beds	39-2					13,109		13,109	
14	TOTAL			$		$ 49,127	$ 75,974		$ 125,101	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (28,957)	$ (28,143)	1
2	Cash-Patient Deposits	52,445	52,445	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,716,610	1,716,610	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,698	33,698	6
7	Other Prepaid Expenses	24,116	24,116	7
8	Accounts Receivable (owners or related parties)	30,017	163,032	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,827,929	$ 1,961,758	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	4,012,515	4,012,515	15
16	Equipment, at Historical Cost	1,427,861	1,427,861	16
17	Accumulated Depreciation (book methods)	(1,561,336)	(1,977,785)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,879,040	$ 6,568,315	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,706,969	$ 8,530,073	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 206,093	$ 206,093	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,445	52,445	28
29	Short-Term Notes Payable	3,851,943	7,851,943	29
30	Accrued Salaries Payable	299,968	299,968	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,706	10,706	31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,979	183,979	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,605,134	$ 8,605,134	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,605,134	$ 8,605,134	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,101,835	$ (75,061)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,706,969	$ 8,530,073	48

***(See instructions.)**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,038,241	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,038,241	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	308,292	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(407,192)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Capital Contributions**	162,494	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 63,594	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,101,835	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,047,608	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,047,608	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	928,110	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,445,037)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Capital Contributions**	394,258	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,122,669)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (75,061)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,833,060	1
2	Discounts and Allowances for all Levels	(463,752)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,369,308	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	225,383	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 225,383	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	15,715	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,500	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,163	19
20	Radiology and X-Ray	1,535	20
21	Other Medical Services	58,513	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 135,426	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	159	28
28a	Rental Income	67,076	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 67,235	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,797,352	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,654,115	31
32	Health Care	2,739,083	32
33	General Administration	1,252,344	33
	B. Capital Expense		
34	Ownership	1,632,092	34
	C. Ancillary Expense		
35	Special Cost Centers	125,101	35
36	Provider Participation Fee	86,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,489,060	40
41	**Income before Income Taxes (line 30 minus line 40)****	308,292	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 308,292	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Cash Basis Taxpaye

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,787	1,959	$ 51,243	$ 26.16	1
2	Assistant Director of Nursing	2,518	2,824	67,887	24.04	2
3	Registered Nurses	36,362	38,320	888,362	23.18	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	110,421	118,048	1,091,947	9.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,005	2,237	40,961	18.31	9
10	Activity Assistants	11,147	12,380	117,991	9.53	10
11	Social Service Workers	6,100	6,614	79,943	12.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,804	35,407	298,915	8.44	15
16	Dishwashers					16
17	Maintenance Workers	6,655	7,167	92,277	12.88	17
18	Housekeepers	24,465	26,167	204,881	7.83	18
19	Laundry	4,368	4,934	40,494	8.21	19
20	Administrator	1,852	2,086	73,145	35.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,861	10,813	159,406	14.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,158	4,518	63,757	14.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,503	273,474	$ 3,271,209 *	$ 11.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	270	$ 13,497	1-3	35
36	Medical Director	780	15,600	9-3	36
37	Medical Records Consultant	98	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	321	3,212	10-3	39
40	Physical Therapy Consultant	768	25,342	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,500	11-3	44
45	Social Service Consultant	29	1,356	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,304	$ 64,539		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,179	$ 142,118	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,179	$ 142,118		53

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Elwart	Administrator	N/A	$ 73,145
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,145

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 174,800
Administrative Consultant	4,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 179,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 9,294
Power Software Development	Data Processing	4,595
Blitz Comm. Inc.	Data Processing	3,269
Horizon Healthcare	Data Processing	390
Personnel Planners, Inc.	Payroll Tax Consultant	1,155
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,365
Panarese & Panarese	Legal	5,974
Winston & Strawn	Legal	1,914
Sanford Kahn, Ltd.	Legal	2,332
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,538

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,688
Unemployment Compensation Insurance	19,536
FICA Taxes	242,831
Employee Health Insurance	114,961
Employee Meals	19,934
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	12,683
Uniform Allowance	5,086
Retirement Plan Contribution	11,885
Dental Insurance	6,721
Employment Fees	10,031
Lancaster Allocation	22,492
TOTAL (agree to Schedule V, line 22, col.8)	$ 492,848

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	14,702
Health Care Worker Background Check	
(Indicate # of checks performed 30)	360
Licenses & Fees	13,896
Promotional Advertising	31,417
Dues & Subscriptions	244
Charitable Contributions	698
Lancaster Allocation	5,864
Less: Public Relations Expense	(698)
Non-allowable advertising	(37,281)
Yellow page advertising	(3,265)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,337

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,123
Seminar Expense	4,388
Lancaster Allocation	192
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 5,703

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting and Decorating	1998	$ 24,627	3	$ 4,104	$ 8,209	$ 8,209	$ 4,104	$	$	$	$	$
2	Painting and Decorating	Jul-99	26,214	3		4,369	8,738	8,738	4,369				
3	Painting and Decorating	Dec-99	13,669	3		2,278	4,556	4,556	2,279				
4	Painting and Decorating	Jan-00	4,221	3			703	1,407	1,407	704			
5	Painting and Decorating	Feb-00	10,169	3			1,694	3,390	3,390	1,695			
6	Painting and Decorating	Mar-00	606	3			101	202	202	101			
7	Painting and Decorating	Apr-00	2,192	3			365	730	730	366			
8	Painting and Decorating	Jul-00	241	3			40	80	80	41			
9	Painting and Decorating	Aug-00	592	3			98	198	198	98			
10	Painting and Decorating	Sep-00	2,588	3			431	863	863	431			
11	Painting and Decorating	Oct-00	8,123	3			1,354	2,707	2,707	1,355			
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 93,242		$ 4,104	$ 14,856	$ 26,289	$ 26,975	$ 16,225	$ 4,791	$	$	$

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **86,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,934** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.